2015

Expanding Mental Health Consultation in Early Head Start: Recommendations for Supporting Home Visitors in Increasing Parental Engagement

Samantha L. Pittenger
University of Nebraska-Lincoln, samantha.friedenberg@gmail.com

Tori R. Van Dyk
University of Nebraska–Lincoln, tsmith18@huskers.unl.edu

Alayna Schreier
University of Nebraska-Lincoln, alayna.schreier@gmail.com

Michelle Haikalis
University of Nebraska–Lincoln, michellehaik@gmail.com

Mary F. Flood
University of Nebraska-Lincoln, mflood2@unl.edu

See next page for additional authors

Dialog, 18(*2*), 119-135

ISSN: 1930-9325

DIALOG FROM THE FIELD

Expanding Mental Health Consultation in Early Head Start: Recommendations for Supporting Home Visitors in Increasing Parental Engagement

Samantha Pittenger, Tori Van Dyk, Alayna Schreier, Michelle Haikalis, Mary Fran Flood, and David Hansen

Early Head Start strongly emphasizes the importance of intervening with the entire family to promote healthy child development. Parents, in particular, are recognized as their child's most important teacher. While Early Head Start performance standards currently mandate mental health consultation to identify and intervene with child mental health problems, there is little direct focus on the role of consultation in managing parental mental health concerns. This is problematic given that a wide body of literature outlines the impact of parental mental health on engagement in home-based programs such as Early Head Start. Investigations within the home visiting field have also shown persistent requests from staff for further support in addressing these barriers to engagement. Mental health professionals can be instrumental in providing support and education to home visitors dealing with parental mental health concerns, although formal guidelines are generally silent on best practices for establishing and maintaining effective consultation relationships. This Dialog from the Field discusses the issues posed to family engagement by parent-related problems such as mental illness. Synthesizing experience from consultation provided to an Early Head Start program with research from the field, we present a model expanding mental health consultation to address parent and family concerns.

Keywords: Consultation, Mental Health, Early Head Start, Home Visiting, Parental Engagement

Since its inception in 1994, Early Head Start (EHS) has provided support to thousands of children and families each year through home-based programs, helping to promote healthy child and family development and build strong communities. An integral part of these EHS programs are the home visiting staff who are responsible for conducting weekly, 90-minute sessions with parents and children. During these sessions, home visitors, who may be referred to by a number of titles (e.g., "family advocates" or "family educators"), establish relationships with parents and support them in their parental roles of caregiver and teacher. Through collaboration with health care, child development, and mental health professionals, as well as a network of community services, EHS home visiting and administrative staff work to foster growth from the prenatal

period through toddlerhood by building healthy relationships between children and parents. While goals are largely focused on child outcomes, Head Start programs take a two-generational approach, recognizing that parents are the first and foremost teachers in children's lives (Henrich & Gadaire, 2008). EHS home-visiting programs must not only include opportunities for parents to collaborate and be involved in their child's education but must also incorporate parents' personal development into program reach (U.S. DHHS, 2009, 45 CFR Chapter XIII § 1304.40). These requirements highlight encouraging parent involvement and fostering parental growth as two important goals of EHS; however, program staff often face challenges to the accomplishment of these goals.

Evaluation of the program's two-generational approach has shown that both parents and children experience benefits when families enroll and participate in EHS services. The Early Head Start Research and Evaluation Project (Love et al., 2002) showed that children enrolled in home-based services exhibited gains in language ability and social-emotional functioning as measured through interactions with their parents. Further, enrolled parents reported less stress related to their parenting role, more self-sufficiency, and showed more engagement with their children in play and educational activities (Love et al., 2002). An examination of the impact of EHS on outcomes at ages 2, 3, and 5 years showed similar effects for children as well as reduced incidence of maternal depression and household member drug or alcohol problems (Vogel, Brooks-Gunn, Martin, & Klute, 2013). However, in order for children and families to achieve the gains associated with enrollment in a home-visiting program, they must participate *and* be engaged in program activities. In fact, children and families are likely to experience more gains when a higher dose of the home visiting program is received (Peacock, Konrad, Watson, Nickel, & Muhajarine, 2013). Without parent participation, families are at higher risk for dropping-out of early intervention programs (Roggman, Cook, Carla, & Raikes, 2008), something that frequently occurs in home-visiting programs. Thus, maximum benefit to families is not likely to occur without active parental engagement (Korfmacher et al., 2008).

Prinz and Miller (1991) describe engagement as an active process of accessing what a program has to offer, including cooperation during visit activities and efforts made to extend learning in between scheduled visits in addition to regular attendance. Others emphasize the importance of behavioral and emotional involvement with the program as evidenced by actively seeking more opportunities and information beyond what regularly scheduled visits provide (Lefever, Bigelow, Carta, & Borkowski, 2013). Recently, parental engagement has become a focus of scrutiny and intervention, as it has been identified as a major barrier to program outcomes (Henrich, 2013). This paper focuses on the perpetual challenge that home-visiting programs face in trying to gain and maintain parental engagement (Wagner, Spiker, Inman Linn, & Hernandez, 2003), provides a case example highlighting these challenges, and presents a model for supporting EHS staff in promoting engagement by utilizing existing mental health consultation services.

THE TASK OF INITIATING AND MAINTAINING PARENT ENGAGEMENT

Parent involvement in home visiting programs is imperative as it is a key factor in the success of interventions with young children (Korfmacher et al., 2008). Home visiting programs emphasize the importance of the parent-child relationship but also recognize that the relationship between home visitor and parent may be equally as important to family outcomes (Brophy-Herb et al.,

2009). Developing and maintaining the home visitor-parent relationship does not solely lie in the hands of parents, but is a product of the efforts by both parties (Korfmacher et al., 2008). Beyond simply providing opportunities for parents to collaborate and gain from EHS, the program recognizes that parent and family engagement must be actively sought and consistently supported. The Parent, Family, and Community Engagement Framework (PFCE; US DHHS, 2011) was developed as a response to the recognition that parent engagement is both crucial to the success of the program and that it stems from the efforts of both parent and home visitor, with support from all systems and service areas (U.S. DHHS, 2011). Consequently, home visitors are often encouraged to identify the needs of mothers and other caregivers so that parents can connect with and best utilize services provided by home-based programs (Azzi-Lessing, 2011). Additionally, EHS program requirements include opportunities for parents to collaborate and be involved in their child's education as well as incorporate parents' personal development in family partnership agreements, tools used to set and attain family goals (U.S. DHHS, 2009, 45 CFR Chapter XIII § 1304.40).

Challenges Home Visitors Face in Achieving Parental Engagement

Home visitors face many challenges to engaging parents in their child's education, and therefore in the EHS program. Some frequent challenges include helping parents understand child development and encouraging parents to enter a teaching role for their child (Honig, 1979). As discussed above, EHS has been aware of this issue for decades and has implemented various solutions. For example, the PFCE provides specific guidelines for agencies to maximize participation and program reach. Improving family well-being is identified within the Family Engagement Outcomes of the PFCE, and contracting with a mental health consultant is recommended for programs to address overall family needs related to their well-being. Communication with these experts may also be necessary for home visiting staff to address some less-frequently occurring, although equally as threatening, risks to parental engagement.

Parental risk factors for poor engagement. So what is it that makes parental engagement such a challenging task? There are specific and identifiable parent and family characteristics that may impede engagement with EHS home visiting services such as feelings of vulnerability, cognitive deficiencies, substance abuse, domestic violence, and mental health issues. Often, parents are simply reluctant to be open and honest with home visitors fearing that they may be making themselves vulnerable by sharing information with perfect strangers or with representatives of governmental systems. Many of the families served by EHS experience numerous stressors, including family problems, social isolation, and job insecurity. However, parents may feel more comfortable discussing basic needs rather than the psychosocial problems they are facing, especially during the earlier stages of the parent-home visitor relationship (Tandon, Mercer, Saylor, & Duggan, 2008).

Parents with cognitive deficiencies are overrepresented in Head Start populations and bring their own challenges to effective engagement with the program (Azar, Miller, & Stevenson, 2013). For example, parents with low IQ, developmental disabilities, learning disabilities or even sub-clinical cognitive deficiencies may experience difficulties during activities presented in home visit lesson plans and carrying out between-visit homework assignments. Parents with cognitive deficiencies may have impairments processing social

information which interferes with their parenting abilities as well as their capacity to engage with the home visitors that are providing services to them (Azar, Reitz, & Goslin, 2008; Azar, Stevenson, & Johnson, 2012). Thus, to effectively initiate and maintain engagement with these parents, home visitors must modify their approach to presenting and sharing their learning curriculum with families.

Substance abuse, domestic violence, and mental health problems tend to be grouped together as they pose distinct challenges to implementing home visiting services and are often not recognized by home visitors (Tandon et al., 2008). The presence of these issues is not only detrimental to the effectiveness of EHS, but is also associated with poor child outcomes such as abuse, neglect, poor school readiness, and insecure parent-child attachments, making identification and intervention imperative (Azzi-Lessing, 2011). Families with histories of substance abuse, domestic violence, and parental mental health issues are considered high risk due to these potential poor outcomes and also because they tend to receive fewer home visits and drop out of programs more frequently than lower risk enrolled families (Azzi-Lessing, 2011). In fact, parents with fewer psychological issues may be more likely to engage with home visitors because they are more likely to utilize emotional and instrumental support (Florian, Mikulincer, & Bucholz 1995; Korfmacher et al., 2008; Wallace & Vaux, 1993).

Home visitor challenges influencing parental engagement. Administrators and home visitors recognize the threats to the success of EHS and overall child well-being posed by parental mental health concerns but seem poorly equipped to address threats at the front line. Rigorous research studies and meta-analyses have shown that home visiting programs are often effective across child developmental outcomes but fail to cause change in the areas of child abuse and parenting stress (Duggan et al., 2004; Sweet & Appelbaum, 2004). Reaching and engaging higher risk families can be a frustrating, time-consuming, and emotionally taxing task for home visitors (Gill, Greenberg, Moon, & Margraf, 2007), and sometimes frustrations arise when home visitors aren't able to identify what barriers are in place with a specific family. Systematic evaluation has also shown that the complexity of problems exhibited by high needs families often surpasses the ability of paraprofessional home visitors, both in identifying problems and addressing them (Chaffin, 2004; Duggan et al., 2004; Eckenrode et al., 2000; Tandon et al., 2008). For example, it might be unclear to home visitors whether parents have mental health issues, substance abuse concerns, or both (Jones Harden, Denmark, & Saul, 2010) and even when these risks have been successfully identified, it may be unclear how to link families to resources available to address their concerns (Duggan et al., 2004).

There are a number of reasons why issues such as parental mental health problems, substance abuse, and domestic violence might go unaddressed. Home visitors may be reluctant to discuss concerns because they fear it will cause a strain in their relationship with parents, or they may be embarrassed by the thought of touching on these sensitive issues (Hebbeler & Gerlach-Downie, 2002; Kitzman, Cole, Yoos, & Olds, 1997). Recognizing the gravity of maternal depression, violence in the home, or active substance use and abuse, home visitors might be unsure of how to effectively communicate with parents regarding the threats posed to their family and the resources available to help lessen these threats (Jones Harden et al., 2010). These findings suggest there is a pervasive issue in the realm of home visiting: a lack of training for home visitors in identifying, understanding, and addressing adult mental health, substance abuse, and violence concerns (Gill et al., 2007; Tandon et al., 2005; Tandon et al., 2008; Wasik & Roberts, 1994).

Issues unique to programs employing paraprofessional home visitors are made salient when compared to those with professional staff. For example, one of the most well-established home visitation programs is Nurse Family Partnership (NFP), developed by David Olds and his research team in the 1970s. NFP is designed to target parental behaviors and environmental conditions in order to improve outcomes related to pregnancy, child health and development, and maternal life-course (Olds, 2006; Olds et al., 2013). While EHS employs paraprofessionals as home visitors, NFP utilizes trained nurses in order to increase competence and credibility with participating families (Olds, 2006; Olds, Hill, O'Brien, Racine, & Moritz, 2003). In a study examining the effectiveness of paraprofessionals compared to trained nurses, Korfmacher, O'Brien, Hiatt, and Olds (1999) found fewer significant results on key outcomes with the use of paraprofessionals. Further, families who received nurse home visitation were less likely to drop out and completed more visits as compared to families who received services by paraprofessionals. EHS and NFP are disparate programs with different target populations, although the difference in outcomes highlights issues posed by employing paraprofessional front-line workers.

Across home visiting programs designed for expectant families and those with young children, nearly half of home visitors (up to 45%; Sweet & Appelbaum, 2004) are paraprofessionals. This term, defined by Korfmacher and colleagues (2008, p.184), refers to "service providers who do not have degreed or formal training in a professional service such as counseling, social work, nursing, medicine, psychology, or child development." Thus, unless independently sought by programs, home visitors are unlikely to receive training in addressing parental mental health concerns and rarely have educational backgrounds that provide them training in adult issues such as mental health and substance abuse problems. Within EHS, performance standards require that beyond child development and safety/nutrition experience, home visitors have knowledge of adult learning principles and family dynamics, although there are no clear regulations for educational background or training and there is no mention of adult mental health issues (U.S. DHHS, 2009). However, it should be stressed that home visitors without a formal education in adult mental health are likely still suited for the job. For example, characteristics such as being of a similar ethnic background (Daro, McCurdy, Falconnier, & Stojanovic, 2003) or sharing similar life experiences as families (Brookes, Summers, Thornburg, Ispa, & Lane, 2006) have been related to positive program outcomes. Thus, the solution is not to use formally trained professionals, but to educate and support paraprofessional home visitors in the identification, assessment, and management of substance abuse and mental health concerns (Chaffin, 2004), and encourage the development of skills so that home visitors can build and maintain relationships with high-risk families (Azzi-Lessing, 2011).

In their review, Peacock and colleagues (2013) note that home visiting programs are most effective when staff receive training and support necessary to serve their enrolled population. Unfortunately, earlier investigations have revealed inadequate levels of training and support for home visitors (Wasik & Roberts, 1994) and there still are not clear guidelines for how much or what type of training might help home visitors manage parental mental health issues. Further, lack of clear program guidelines may promote uncertainty regarding home visitor roles in addressing parental mental health needs (Tandon et al., 2008). EHS programs are not required to follow any specific curriculum, allowing for flexibility in the development of family goals and lesson planning which leaves room for home visitors to tailor a family's plan to address parental mental health concerns (Lombardi & Bogle, 2004); however, many home visitors feel poorly equipped to work with families on these issues. For example, home visitors report having little

training in dealing with the tension between wanting to address mental health or substance abuse concerns and families identifying other needs as more pressing (Tandon et al., 2008). Although the EHS performance standards require pre-service and ongoing training for home visitors, amount and content are not specified (U.S. DHHS, 2009, 45 CFR Chapter XIII § 1306.23). Tandon and colleagues (2008) found that when training is provided, it often helps home visitors identify red flags with particular families but does not enhance skills necessary for home visitors to effectively facilitate referrals to appropriate entities.

For the reasons outlined above, the field sees a persistent request from home visiting staff for programs to provide more training and support in the areas of adult mental health, substance abuse, and domestic violence (Gill et al., 2007; Tandon et al., 2005). The rest of this paper presents a model to use services already in place within EHS (i.e., mental health consultation) that may be a feasible solution to the problem of training and support identified by home visitors.

UTILIZING MENTAL HEALTH CONSULTATION TO ADDRESS PARENT-RELATED ISSUES

Mental Health Consultation in Early Head Start

Formalizing the process of mental health consultation is strongly credited to Gerald Caplan (Mendoza, 1993), who established it as a means of assisting individuals and programs with problems that are outside of their scope of expertise, and provided general principles from which to implement it (Caplan, 1970). This type of consultation may be used to help a specific client or to increase the capabilities of a program and its staff in addressing issues they commonly face. Within EHS and other early childhood programs, there has been much examination of the role and impact of mental health consultation in regard to infant and child mental health (Conners-Burrow et al., 2013; Green, Everhart, Gordon, & Garcia Gettman, 2006). In the context of EHS, mental health consultation serves as a "problem solving and capacity building intervention implemented within a collaborative relationship between a professional consultant with mental health expertise and one or more individuals… with other areas of expertise" (Cohen & Kauffman, 2005, p. 4).

EHS programs value collaboration with other community entities and recognize the combined power of community and program to better serve enrolled families (U.S. DHHS, 2009). In addition to building community partnerships, EHS program requirements mandate procurement of mental health consultation for the purpose of handling child mental health concerns. Specifically, requirements state that agencies must secure the services of mental health professionals on a schedule of sufficient frequency to enable the timely and effective identification of and intervention in family and staff concerns about a child's mental health (U.S. DHHS, 2009, 45 CFR Chapter XIII § 1304.24). These mental health program services must also include a regular schedule of on-site consultation involving the mental health professionals, program staff, and parents (U.S. DHHS, 2009, 45 CFR Chapter XIII § 1304.24). As stated above, the PFCE framework also recommends contracting with mental health consultants to meet engagement goals (US DHHS, 2011); however, there are no guidelines describing how to use that consultation in an effective manner. In fact, the consultation literature completely ignores how this service may be used to enhance the home visitor-parent relationship and work to address non-child-specific concerns to family engagement and healthy development. The

sections below provide a glimpse into the mental health consultation experiences of the authors and describe how consultation practices may be used to address parental mental health concerns that serve as barriers to program engagement.

A Case of Consultation between EHS and University-Based Mental Health Consultants

The authors of this paper serve or have served as mental health consultants to an EHS home based program in a partnership with a large Midwestern university. More than a decade of collaboration between the university and EHS shows a pervasive concern related to training and support for home visitors in identifying and overcoming barriers to parental engagement, including mental health issues. There are frequent requests from EHS staff for support from the university mental health consultants, ranging from informal solicitations for advice in working with parents, requests for joint home visits to observe and interact with families, to requests for didactic and interactive training in adult-related issues. Consultants are available as needed to home visitors and for scheduled multidisciplinary team meetings. Additionally, the consultants are involved in the mental health screening process for all enrolled families, as they have developed and selected the screening measures currently in use and provide written reports of screening results.

To better support our anecdotal evidence that these local home visitors feel challenged by parental mental health issues, consultants recently collected qualitative information from both home visitor-initiated and consultant-initiated discussions for a period of six months. All home visitors employed at the local EHS (N = 20) were invited to volunteer their participation in this case study; 11 agreed to participate, though one abruptly left the program, resulting in a final sample of 10 home visitors. All participants were women, 90% were European-American with one participant identifying as North African, and were 34 years old on average (SD = 9.9). Home visitor-initiated consults were defined as any time a home visitor sought spontaneous consultation by coming to the consultant office or reaching out via email or phone. The consultant-initiated meetings were typically those surrounding mental health screening reports, and were primarily intended to discuss concerns noted in screening measures. During all consultations, the mental health consultant completed a coding form to indicate type of consultation (i.e., home-visitor or consultant initiated), date of consultation, duration (in minutes), and various family-level and consultation specific pieces of data. For example, a number of parent and child concerns were coded for each consultation. Parent concerns included reports of depressive symptoms, parental stress, caregiver mental illness, and caregiver substance or alcohol use/abuse issues. Child-related concerns included behavioral problems, developmental delays, and issues related to a screening tool for autism spectrum disorders (Checklist for Autism in Toddlers; Baron-Cohen, Allen, & Gillberg, 1992). Two categories – history of abuse/neglect/child protective service (CPS) involvement/domestic violence and current abuse/neglect/CPS involvement/domestic violence – were considered as both child and parent concerns. Consultation-specific information included: whether consultant and home visitor discussed services available to address concerns, family strengths, home visitor strengths, a plan to begin addressing identified problems, and perceived barriers to implementing that plan. Additionally, consultants noted whether a plan for remediating identified problems was shared

with the home visitor's supervisor and if the consultant and home visitor problem solved or role played strategies to overcome perceived barriers.

A total of 43 consultations were coded over a six-month period: 24 home visitor-initiated and 19 consultant-initiated. When topics of home visitor- and consultant-initiated discussions were aggregated, there was an even breakdown of which family member was discussed. Specifically, parent related concerns were discussed in 39% of consults, child concerns in 27%, and concerns relating to both parent and child in 34%. However, when consultation types were examined separately, there were large discrepancies. The most frequent concerns noted during consultant-initiated discussions were parental reports of child behavior problems. Alternately, the most frequently discussed concerns during home visitor-initiated consults were focused on parental concerns. Over half of all home visitor initiated consults included some discussion of CPS-related issues with 53.8% of consults addressing current CPS concerns and 23.1% addressing historical CPS concerns. Additionally, about one-third of home-visitor initiated meetings included discussion of parental mental health concerns (38.5%) and parental stress (34.6%). Bringing this information to the local EHS administration, we hypothesized that the discrepancy between consultant initiated and home-visitor initiated discussions may exist, in part, because consultants sought contact after initial screening measures were completed – which occurs early in a family's enrollment – while home-visitors sought consultation after having served the families and, presumably, having built some rapport.

As stated above, consultants helped home visitors identify appropriate services to address concerns noted and asked home visitors to identify barriers to service delivery. In addition to parenting classes and education regarding normal child development, home visitors often identified a need for individual mental health services, safety planning, and law enforcement involvement with their families. Overall, about 26% of families were referred to mental health services, with 50% of families identified as high needs (i.e., risk factors to healthy child development present) being referred. Consistent with previous research (Tandon et al., 2008), home visitors perceived minimal parent engagement, unaddressed parental stressors and mental health issues, and parents not being open to home visitor recommendations as the most frequently occurring barriers to families engaging in recommended services.

These findings suggest that (a) parent concerns may surface later in the parent-home visitor relationship, (b) these concerns are perceived by home visitors as major barriers to service delivery and engagement, and (c) home visitors seek opportunities to discuss these problems with mental health consultants. As noted previously, caregivers may shy away from psychosocial issues they are facing and prefer to discuss basic family needs with home visitors (Tandon et al., 2008). For this reason, parent-related concerns often are not apparent at the outset but surface after the home visitors work to build relationships with their families and make themselves trusted support persons to parents. Consultant-initiated discussions were primarily focused on screenings that occurred early in enrollment and therefore seemed to miss parent-related concerns influencing the family and relationship with EHS. Home visitors included in this examination were often able to identify parental mental health or substance abuse concerns, contrary to prior investigations (e.g., Duggan et al., 2004), although their requests for consultation regarding these concerns reflect a lack of skill and/or perception of ability to adequately address them with families.

This case study has several limitations that should be considered when interpreting findings from the data. For example, our sample included only 10 participants who were all female and primarily European-American. Although these home visitors were working with

families representative of the demographics of the state within which they reside, the study may not capture cultural differences regarding the use of mental health consultation. Importantly, it should be noted that mental health consultants coded their consultations with home visitors in real time and these consultations were not audio or video recorded. This prevented independent coding of the data and findings should be interpreted with caution since trustworthiness has not been established. Despite this limitation, the data provide preliminary evidence that home visitors recognize parent-related concerns such as mental health issues and substance/alcohol use and abuse as threats to home visiting efficacy by precluding family engagement. In addition, home visitors recognize the importance of addressing child abuse and neglect concerns as evidenced by their requests for consultation regarding current and prior CPS involvement. While efforts should be made to conduct more rigorous evaluations of mental health consultation in EHS, this case study supports our hypothesis that home visitors feel ill-prepared to manage challenges posed by parental mental health issues, substance abuse, and family violence. Further, these home visitors seemed willing to utilize available consultation to improve their ability to manage these issues. The following section outlines recommendations for utilizing mental health consultation to address home visitor concerns through support, education, and skills training.

RECOMMENDATIONS FOR AN EFFECTIVE CONSULTATION MODEL

We propose that the same mental health consultation services procured for purposes of child social and emotional well-being be used to provide ongoing training and support to home visitors and other EHS staff in managing parental mental health, substance or alcohol use/abuse issues, domestic violence, and other parent-related concerns. These issues must be addressed not only to improve program engagement, and thus program outcomes, but to reduce threats to healthy child development. For example, by addressing the parental behaviors so largely associated with maltreatment (Famularo, Kinscherff, & Fenton, 1992; Smith, Davis, & Fricker-Elhai, 2004), child abuse and neglect may be prevented or remediated, thus promoting healthy development and in turn improving program outcomes.

Most mental health professionals are trained in working with adult mental health issues and through this perspective can provide support to home visitors while also incorporating home visitor skills and experience to address concerns (Cohen & Kauffman, 2005). Additionally, consultants should be used to help facilitate family access to services in the community. As stated above, most home visitors are not trained on these issues, nor is it in their job description to serve as mental health counselors to families. Rather, home visitors may help families by identifying problems, providing information regarding services available to address them, and linking families to appropriate services. By working with home visitors, consultants can help design and implement mechanisms for programs to identify these families and connect them with services, as recommended by Tandon and colleagues (2008). Once supportive services are in place, home visitors can return their focus to child development and receive ongoing help from mental health consultants to assume a case manager role in regard to the parental issues identified.

There is a clear need and desire from home visitors to receive training in an effort to address these threats to program engagement; however, training and support in these areas is not one-size-fits-all. One must consider the complex relationship between family needs, prior home

visitor experience, and home visitor personal characteristics when navigating a plan to maintain family engagement and connect families to necessary support services (Tandon et al., 2008). The different experiences, education, and prior training that staff have calls for tailoring support and supervision as well as professional development opportunities afforded to home visitors (Gill et al., 2007). Thus, any training model must be multi-faceted, take into account the specific needs of the population it intends to serve, and encourage flexibility as both staff and program participants are dynamic.

Components of an Effective Consultation Model

Effective consultation is imperative to successfully address parental issues of mental health, substance abuse, and domestic violence; however, as previously stated, there has been little to no guidance in the literature regarding how home visitors and mental health consultants should work together to overcome these barriers and promote optimal parental engagement. Many home visitors are paraprofessionals (Sweet & Appelbaum, 2004) with varying educational backgrounds and do not receive formal training on issues of adult mental health (Wasik & Roberts, 1994). Although performance standards require home visitor knowledge of adult learning principles and family dynamics (U.S. DHHS, 2009), they do not specify prerequisite understanding of adult psychopathology and treatment needs. Thus, many individuals hired into home visiting roles are poorly equipped to identify and address issues of parental mental health with families. This limitation often persists even after the required EHS home visitor new employee and in-service training, despite requests from home visitors to receive this training (Gill et al., 2007; Tandon et al., 2005) and prior recommendations for "more and varied supervision" methods to help home visitors navigate parental mental health, substance abuse, and domestic violence issues (Tandon et al., 2008, p. 425). Thus, at the foundation of an effective consultation model should be an ongoing training process that directly addresses these issues and provides home visitors with practical knowledge and skills. In our work with home visitors, we have identified three research-based methods to be effective in delivering education and training on parent and family concerns: didactics (e.g., workshops), skills practice (e.g., coaching during joint home visits), and support (e.g., multidisciplinary team meetings).

Didactics. Because home visitors may have never received formal training on adult mental health issues, didactic education can provide the basic knowledge necessary to address such broader family concerns. Research suggests that workshops and seminars that provide information and discussion on theory are efficient ways of disseminating information (Fixsen, Naoom, Blase, Friedman, & Wallace, 2005). Further, home visitors report knowledge and understanding of issues on which they receive training (Tandon et al., 2008), demonstrating the effectiveness of didactic education. In addition to the pre-service training regarding curriculum and child development provided to home visitors, it is strongly recommended that staff receive in-service training throughout the year to prepare them for challenges to family engagement and help them better understand the families they are serving and resources available in the community (Coffee-Borden & Paulsell, 2010). For example, formal training on stages of change and motivational interviewing (see Prochaska & DiClemente, 1983 and Miller, 1983 for descriptions of these strategies) have been reported as particularly helpful by program staff with whom the authors work, and provide skills that can be used when addressing identified risk

factors within families, such as substance use or mental health problems. Home visitors have found these models especially useful for conceptualizing and working with families who are resistant to change and appear unmotivated to engage in program activities or recommended services.

Skills practice. Although needed to provide foundational knowledge, didactic training alone does not effectively facilitate implementation of skills when working directly with families (Fixsen et al., 2005; Joyce & Showers, 2002). According to the National Implementation Research Network (2013), on-the-job coaching and consultation is where most skills are learned well enough for future implementation. In fact, research with teachers (Joyce & Showers, 2002) and addiction counselors (Dansereau & Dees, 2002) has found poor execution of skills when training consists solely of didactics. Including skills training within a consultation model is important as it supplements foundational knowledge by providing the relevance, context, and opportunity for practical implementation of information (Spouse, 2001).

The authors have found skills training to be effective in multiple different settings, including individual consultation and in-service trainings. For example, when providing didactic training on facilitating stages of change, home visitors were particularly receptive to the incorporation of role-plays and skills-based practice of techniques such as utilization of appropriate reflections and open-ended questioning. Role-plays are an important part of training to practice skills as well as help home visitors become less judgmental and more empathic toward their families (Honig, 1979). Coaching may also be used to increase home visitor ability to address key parental issues (National Implementation Research Network, 2013; Spouse, 2001). Through this process of skills-based training, coaches are used to help teach home visitors how to implement strategies first-hand and to provide assessment and feedback. In our experience working with home visitors, we have found coaching during joint home visits to be an effective way to demonstrate techniques and to support home visitors in practicing implementation of skills. Joining home visitors in the field, as they work, helps consultants better conceptualize strengths and weaknesses as well as provide in-the-moment support. The presence of mental health consultants in preschool classrooms has resulted in enhanced quality of teacher-child interactions (Conners-Burrow et al., 2013), and joint home visits may have the same effect for both home visitor-child and home visitor-parent interactions. The goal of inviting mental health consultants to join home visits is not to take responsibility away from the staff requesting it (Cohen & Kauffman, 2005), but to provide home visitors the guidance and support needed for them to confidently and effectively attend to family issues. This scaffolding approach not only helps home visitors gain competence in independent implementation of skills, but also increases parental engagement by maintaining rapport between the home visitor and family. For example, we have frequently used coaching to shape home visitor skill in promoting the use of effective discipline strategies and to reduce the use of corporal punishment. Consultants provide coaching for behind-the-scenes activities such as forming lesson plans and selecting lesson materials as well as on-the-job during home visits with families. After receiving this support, home visitors often report success in encouraging parents to implement time out procedures in the absence of the mental health consultant coaches.

Support. While support may be expressed in a variety of ways, at its core it reflects one giving help or assistance to another to prevent a loss of courage and promote persistence. Prior research has identified ongoing support to home visitors as central to increasing parental

engagement in home-based programs (Korfmacher et al., 2008) and preventing home visitor burnout (Gill et al., 2007). Thus, a primary component of providing effective consultation should be activities that contribute to the program's support of home visitors, such as supervision, professional development, and ongoing training. Mental health consultants can easily be incorporated into these activities to provide support to home visitors in a variety of ways. Complementary with skills training, social and emotional support of home visitors is linked to less burnout and improved home visitor self-efficacy (Lee et al., 2013). Spouse (2001) identifies the provision of emotional support as a key component of coaching. By using reflective consultation and showing empathy and understanding (Johnston & Brinamen, 2009), consultants can help identify and acknowledge the difficulties inherent to working with high-risk families, thus providing a sort of collegial social support which may help prevent job burnout (Gill et al., 2007). Additionally reinforcing the need for emotional support, Gill and colleagues (2007) found negative emotionality in home visitors to be associated with a decreased amount of time spent on home visits that, in turn, may hinder parental engagement and ability to maintain rapport. Relatedly, mental health consultants may also use their expertise in stress management to promote home visitor self-care practices via workshops on topics such as relaxation or mindfulness. As consultants with EHS, we often discuss the importance of self-care during individual meetings with home visitors and encourage them to schedule enjoyable or rewarding activities to help manage job stress. Stress management can also be incorporated into large group training sessions. In our practice, we have found employees respond well to presentations regarding mindfulness meditation when presented as a self-care activity.

Finally, mental health consultants should provide support to home visitors as a part of multidisciplinary team meetings (i.e., Family Child Reviews) where parental and family concerns are frequently identified. Involving mental health consultants in these meetings, in addition to availability for unstructured or spontaneous consults, provides home visitors immediate support when addressing parent issues. As mental health consultants, we use Family Child Reviews to gather information about specific families, provide recommendations to home visitors and supervisors, and to acknowledge any negative aspects of working through challenges the home visitor may identify.

Integrating Consultation into Early Head Start Programs

The section above provides a framework from which to build effective consultation; however, challenges are likely to arise when programs attempt to implement new practices. Prior research with Head Start shows the most highly satisfactory consultation occurs when services are provided frequently and when consultants take time to build strong, collaborative relationships with their consultees (Green et al., 2006). In our experience, consultation has been more accepted by program staff when it was integrated into practice as usual, promoting program-wide acceptance of its use to enhance efforts in serving families. This involves encouragement of voluntary/spontaneous use of consultants as well as structured collaborations. Our consultants are incorporated into program services beginning with the initial screening of an enrolled family, jump-starting a system that relies on joint collaboration between home visitor and consultant. To avoid having communication solely based on identified problems, our consultants are also incorporated into scheduled meetings (e.g., Family Child Reviews) and trainings where all aspects of program participation are discussed. Integrating consultants into an EHS program

should be done in an intentional manner, with support from administrators and supervisors prior to working with home visitors. Additionally, consultants should be visible in program offices, be approachable, and should seek out discussion with home visitors on a regular basis.

Even more important than visibility and presence are efforts to reduce the stigma that surrounds issues of mental health and treatment seeking. Perceived stigma surrounding mental health issues is a major barrier to accessing help (Cooper, Corrigan, & Watson, 2003), and this could be reflected in both home visitor and parent/family apprehension to engage with mental health consultation and/or services. Specifically, if program staff hold negative stereotypes and prejudices about mental illness, they will likely be reluctant to discuss the very characteristics that make families high-risk and these problems will be left unaddressed. Consultants must help to normalize mental health care for program staff by providing education regarding the prevalence and potential consequences of unaddressed psychological issues, including substance abuse and domestic violence. Educating home visitors on these issues, in addition to the efficacy of interventions designed to address them, will encourage them to seek consultation if they recognize red flags and help build home visitor confidence in discussing concerns with their families. One can expect that simple exposure to these topics will help reduce the discomfort home visitors may feel in discussing them. Further, teaching home visitors to normalize mental health care may work to decrease stigma held by parents and families thus promoting help seeking behaviors in their enrolled families (Onunaku, 2005). Mental health consultation is not just about addressing problems but should also be used to help promote healthy social emotional development of the entire family. Consistent with the goal of integrating consultation into all program aspects, home visitors and consultants should regularly discuss parent, child, and family strengths to reflect this focus on overall well-being and reduce stigma associated with utilizing mental health consultation.

Relatedly, in conceptualizing families and home visitors, consultants should take into consideration individual characteristics and the ways in which these characteristics may influence willingness to seek and/or be receptive to mental health consultation. For example, consultants should have awareness and understanding of cultural perceptions of mental health, drug or alcohol abuse, and domestic violence as these perceptions may become barriers to effective consultation with home-visitors or implementation of strategies with families. Research suggests that home visitors with similar backgrounds interact more successfully with their families (Daro et al., 2003), perhaps largely because they have a deeper understanding of the family's individual and cultural characteristics. For these reasons, consultants should collaborate with home visitors and utilize their expertise when conceptualizing cases and developing plans to address parental and family issues. For example, the EHS program where the authors provide consultation serves a large proportion of Middle Eastern and Arab American families. Research suggests that significant stigma exists surrounding mental health services, particularly for women, within some Arab cultures (Al-Krenawi & Graham, 2000; Erickson & Al-Timimi, 2001). Subsequently, we had also observed that many Arab American families served by our program were underreporting issues of mental health and substance abuse on screening measures, thus Arab American home visitors were underutilizing mental health consultation. Recognizing the cultural differences in mental health stigma, we were able to provide education to home visitors to help reduce this stigma and provide a rationale for the importance of identifying and addressing these problems. We also worked directly with Arab American home visitors to find more effective and culturally acceptable ways to approach Arab American families about potentially sensitive issues (e.g., maternal depression, substance use).

As stated above, home visitors come from a variety of educational and personal backgrounds (e.g., Gill et al., 2007). Consultants should consider the life and work experience of home-visitors with whom they work, in addition to their interests and educational backgrounds when beginning to provide support. Johnston and Brinamen (2009) also emphasize the importance of maintaining a transactional approach to consultation. In the case of EHS, this involves recognition of the home visitor-family relationship as well as the consultant-consultee relationship and how they influence targets for intervention as well as intervention itself. Being familiar with consultees and conceptualizing their role in working with families and with colleagues helps consultants build on home visitor strengths and tailor support where it is most needed. As with any working relationship, consultants must always strive to respect consultees' autonomy, and this is not possible without first understanding the persons with whom and situations in which one is consulting.

Finally, any consultation model implemented with EHS should follow the tenets of evidence-based practice, which include a combination of best research evidence, clinical expertise, and providing services in a manner that is consistent with characteristics, culture, and preferences of the individuals being served (American Psychological Association, 2006). Thus, EHS should use consultants with experience and training in the areas of parental mental health, substance abuse, and domestic violence and should require that their consultants engage in continuing education activities in order to stay abreast of the most current literature. In addition, it is important that programs evaluate services by eliciting feedback from all relevant parties (including consultants, consultees, and families that may have been impacted by the consultation process) and analyze the effects of consultation on their program. Mental health consultants should monitor their activities and solicit feedback from consultees, supervisors, and administrators to evaluate the effectiveness of their services. Monitoring strategies may include documentation to track general information about consultation use within the program and more specific components such as issues identified and discussed, recommendations given, and resulting actions. When consultation is incorporated into programs in a planful manner, this documentation may also serve to measure whether goals for integrating this service have been met and if consultation is being utilized as initially intended.

CONCLUSION

It is clear that parental mental health, substance abuse, and domestic violence concerns often arise in populations enrolled in EHS, that these issues pose threats to healthy child development, and that they hinder program engagement. Recent investigations have also made clear that the front line service workers who are tasked with maintaining family engagement often feel they do not have the skills necessary to address such complex issues. Failure to address these parent influences on program engagement reduces the effectiveness of the program and places children at risk for maltreatment. While EHS cannot expect to hire home visitors with experience and skills in all of these areas, they do have services in place to provide support to staff, namely consulting mental health professionals. This paper has outlined methods for utilizing mental health consultation to address these gaps in home visitor expertise in an effort to better serve children and families in addition to increasing staff self-efficacy. The next step for EHS programs in promoting family engagement is to incorporate consultation into practice in a more structured manner and evaluate the process and outcome. Future endeavors should (a) further

test the hypothesis that home visitors are challenged by adult-related issues and (b) test the efficacy of any consultation models implemented by employing methodology that may generalize findings to other programs. Following from the case study presented here, investigators should plan for larger scale data collection and incorporate methods of testing trustworthiness of the data. Generalizability may be achieved through longer data collection periods, incorporating data from multiple EHS home visiting programs, and including more diverse home visiting staff. Future research should use methodology that allows for independent coding of consultations. With more standardized methods of consultation use, EHS can work toward focused and specific guidelines to maximize use of this service and improve both job satisfaction and family outcomes.

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